STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain a recordkeeping system that accurately reflected 1 of 4 audit clients (#5). The finding is: Client #5's record was not maintained with correct information. Review of client #5's record revealed his occupational therapy OT assessment referenced "her" within the evaluation. Additional review revealed another client's name. Interview on 8/6/19 with the qualified intellectual disabilities professional (QIDP) confirmed the incorrect information and another client's name should not have been in client #5's record.	W 111	No later than October 4, 2019, the QIDP will assure the occupational therapist will correct the use of the pronoun "her" and remove another client's name on his OT evaluation for client #5, The QIDP will review the need to review evaluations with the OT to ensure that all information is accurate. DHSR - Mental Health AUG 22 2019 Lic. & Cert. Section	10/04/2019
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a client (#1) was afforded dignity regarding the use of a towel placed in her	W 125	No later than October 4, 2019, the QIDP will in-service all staff not to place a towel underneath client #1 while she is being supported in her wheelchair. The residence will purchase a lap blanket for client #1's use when she is cold.	10/04/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Theresa Brechue, Director of Regulatory Affairs | 8/15/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 1 wheelchair and client (#2) with a need for legal guardianship appointed by the court. This affected 2 of 4 audit clients. The findings are: 1. Client #1's dignity was not considered regarding the use of a towel placed underneath her as she sat in her wheelchair During morning observations on 8/6/19 at 6:04am, surveyor observed staff placing a towel in client #1's wheelchair seat and transferring client #1 from her bed to her wheelchair. During morning observations in the home on 8/6/19 at 9:40am, a towel was visible in client #1's wheelchair while she sat and was being loaded on to the van. During an interview on 8/6/19, the home manager (HM) revealed the towel should have been placed in client #1's lap. Further interview revealed client #1's guardian had requested a towel be placed in her lap. 2. Client #2 does not have documentation of a legal guardian. Review on 4/22/19 of client #2's record revealed there is no documentation of guardianship. Further review of client #2's individual program plan (IPP) dated 12/31/18 revealed his legal guardian is his brother. During an interview on 8/6/19, the HM stated she did not realize guardianship paperwork with the state seal was needed as proof of client #2's brother being his legal guardian.	W 125	No later than October 4, 2019, the QIDP or designee will make sure client #2's guardianship paperwork contains the State seal. The QDIP shall ensure that guardianship papers contain the State seal for all future admissions.	10/04/2019
W 218	INDIVIDUAL PROGRAM PLAN	W 218		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 218	Continued From page 2 CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 newly admitted clients (#2,#5) had a physical therapy (PT) assessment to evaluate their current needs. The findings are: Clients #2 and #5 do not have a current PT assessment. a. Review on 8/5/19 of client #2's record revealed there was no current information available to review to indicate a PT assessment was performed. Further review revealed client #2 was admitted to the facility on 12/3/18. During an interview on 8/6/19, the qualified intellectual disabilities professional (QIDP) revealed she thought since client #2 did not need physical therapy an assessment was not needed. b. Review on 8/5/19 of client #5's record revealed there was no current information available to review to indicate a PT assessment was performed. Further review revealed client #2 was admitted to the facility on 11/1/18. During an interview on 8/6/19, the QIDP revealed she thought since client #5 did not need physical therapy an assessment was not needed.	W 218	No later than October 4, 2019, the QDIP will secure a PT assessment for client #2 and #5. Recommendations made in the completed assessment will be incorporated into the plan as appropriate. The QDIP will ensure that a PT assessment is completed for all newly admitted clients.	10/04/2019
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 3 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of medication administration and behavior management. This affected 2 of 4 audit clients (#4, #5). The findings are: 1. Clients #4 and #5 were not allowed to fully participate in medication administration. a. During morning medication administration in the home on 8/6/19 at 7:09am, Staff A dispensed all of client #4's pills from the bubble packs and poured her water. Further observation revealed Staff A did not ask client #4 to participate in dispensing her pills or pouring her water. During an interview on 8/6/19, Staff A revealed client #4 should have been given the opportunity to dispense her pills and pour her water. Review on 8/6/19 of client #4's individual daily living assessment (IDLA) dated 3/8/19 revealed she needs either gestures or partial physical prompts when participating in medication	W 249	No later than October 4, 2019, the QIDP or designee will retrain staff on the need to encourage Client #4 and #5 to participate in med administration. Staff will be retrained on providing gestures or partial physical prompts during med administration as outlined in Client #4 and Client #5's IDLA. These prompts should be used throughout the med administration process, including pouring water and punching medication from the bubble pack.	10/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 4 administration. b. During morning medication administration in the home on 8/6/19 at 7:29am, Staff A dispensed all of client #5's pills from the bubble packs and poured his water. Further observation revealed Staff A did not ask client #5 to participate in dispensing his pills or pouring his water. During an interview on 8/6/19, Staff A revealed client #5 should have been given the opportunity to dispense his pills and pour his water. Review on 8/6/19 of client #4's IDLA dated 3/6/19 revealed he needs either gestures or partial physical prompts when participating in medication administration. During an interview on 8/6/19, the home manager (HM) revealed clients #4 and #5 should have been given the opportunity to participate in medication administration. 2. The facility failed to assure client #4's behavior intervention plan (BIP) was implemented as prescribed. During afternoon observations in the home on 8/5/19 at 3:45pm, client #4 was sitting at the table coloring. While being prompted by staff regarding her activity, client #4 struck staff on their arm. Staff were observed to ignore the behavior. Morning observations in the home on 8/6/19 from 7:43am to 7:46am, client #4 was observed to strike a staff two times on their arm within the three minute time period. Staff were observed to ignore the behavior.	W 249	No later than October 4, 2019, the QDIP will retrain staff on Client #4's behavior plan. Training will include staff consistently providing verbal prompts and physical redirection when client #4 engages in aggressive behavior.	10/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5 During an interview on 8/6/19, Staff A revealed client #4 has a behavior plan. Staff A stated client #4's target behavior is "hitting whoever is sitting besides her when she gets agitated." Further interview revealed staff are to redirect client #4 when she hits at anyone. Review of client #4's BIP dated 6/7/19 to address the client's aggressive behavior which is striking out at others that includes spitting, hitting, scratching, biting, and using items to strike out. Review of the BIP reveals that when client #4 engages in identified behaviors, staff are to use verbal and physical redirection. During an interview on 8/6/19, the qualified intellectual disabilities professional (QIDP) stated that the staff are to provide client #4 with verbal prompts and redirection.	W 249		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure individual program plan (IPP) was revised after the client had successfully completed an objective. This affected 1 of 4 audit clients (#4). The finding is: Client #4's IPP was not revised as needed after completion of an objective and implementation of a new behavioral objective.	W 255	No later than October 4, 2019, the QDIP will revise the IPP to reflect that client #4 had met her previous objective and the new behavior objective will be added to the IPP.	10/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 255	Continued From page 6 Review on 8/6/19 of client #4's IPP dated 2/15/19 revealed a behavioral objective that indicates she will display one or less oppositional behavior episodes for nine out of twelve calendar months by 07/31/2019. Review on 8/6/19 of client #4's record revealed a behavior intervention program (BIP) dated 6/7/19 with an objective statement that indicates she will display no oppositional behaviors for twelve calendar months by 7/31/20. Interview with qualified intellectual disabilities professional (QIDP) on 8/6/19 revealed that the IPP had not been revised to reflect that client #4 had met her previous behavior objective and to include the new behavior objective.	W 255		
W 324	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(ii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all immunizations were current for 2 newly admitted clients (#2, #5). The findings are: A record of clients #2 and #5 immunizations were not kept.	W 324	No later than October 4, 2019, the QDIP or designee will obtain client #2 and #5's immunization record. The QDIP will ensure that immunization records are obtained for all newly admitted clients.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 324	Continued From page 7 a. Review on 8/5/19 of client #2's record revealed he was admitted to the facility on 12/3/18. Additional review of his record revealed no immunization record. During an interview on 8/6/19, the qualified intellectual disabilities professional (QIDP)confirmed client #2's record did not have his immunization record. b. Review on 8/5/19 of client #5's record revealed he was admitted to the facility on 11/1/18. Additional review of his record revealed no immunization record. During an interview on 8/6/19, the QIDP confirmed client #5's record did not have his immunization record.	W 324		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #5 had a comfortable mattress. This affected 1 of 4 audited clients. The finding is: Client #5 was in need of a new mattress. During observations in the group home on 8/6/19 at 6:04am, client #5's twin mattress was noted to have a large indentation or dip in the middle of it.	W 418	No later than August 20, 2019, the QIDP or designee will purchase a new mattress for client #5.	08/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G191	A. BUILDING _____ B. WING _____	08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD HOUSE	2401 DOGWOOD DRIVE NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 418	Continued From page 8 During an interview on 8/6/19, Staff B acknowledged the mattress had a dip in the middle of it and had been there for a while. Interview on 8/6/19 with the qualified intellectual disabilities professional (QIDP) and home manager (HM), HM stated it appeared the mattress had a dip but it was actually due to the covers on the bed. However, after pulling the covers back, QIDP and RM confirmed the mattress was indented in the middle and needed to be replaced.	W 418	Page left intentionally blank	